

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

663-023769

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 99

Primary Registration District No. 5390

Registrar's No. 38

FILED JUN 25 1963

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clarksdale		c. CITY OR TOWN Clarksdale	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home 3 Mi.N.W.		d. STREET ADDRESS (If outside, give location) 3 Mi.N.W.	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph I Brown		4. DATE OF DEATH Month Day Year 6 13 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. FATHER'S NAME Walker Brown		13b. MOTHER'S MAIDEN NAME Matilda Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no		16. SOCIAL SECURITY NO. 66	
17. INFORMANT Ivan Reynolds		Address Clarksdale Mo	

18. CAUSE OF DEATH (Enter only one cause plus immediate cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) arteriosclerosis, general DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from June 1, 1963 to June 13, 1963 and last saw him alive on June 12, 1963 Death occurred at 2 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. S. Sweigert M.D.		22b. ADDRESS Maysville Mo		22c. DATE SIGNED 6/17/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-16-63		23c. NAME OF CEMETERY OR CREMATORY Clarksdale	
23d. LOCATION (City, town, or county) Clarksdale Mo		24. FUNERAL DIRECTOR John Brown		25. DATE RECD. BY LOCAL REG. June 19-1963	
26. REGISTRAR'S SIGNATURE L. E. Davidson					

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

1 0320

2 0320

3

4 0

5 1

6

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9 4201

10

11

12 90-0

13 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John B. [Signature]

Licensed Embalmer No. 3933

P. O. Address Maysville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.